BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SOLEDAD RODRIGUEZ LOPEZ** 3100 Kirkwood Road Corning, CA 96021 Registered Nurse License No. **209795** Public Health Nurse Certificate No. **21280** Respondent	Case No. 2011-549

DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on **May 10, 2011.**

IT IS SO ORDERED **May 10, 2011.**

Jeannie K. Graves

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SOLEDAD RODRIGUEZ LOPEZ** **3100 Kirkwood Road** **Corning, CA 96021** **Registered Nurse License No. 209795** **Public Health Nurse Certificate No. 21280** Respondent.	Case No. 2011-549 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") is the Executive Officer of the Board of Registered Nursing. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Judith Loach, Deputy Attorney General.

2. Soledad Rodriguez Lopez ("Respondent") is representing herself in this proceeding and has chosen not to exercise her right to be represented by counsel.

3. On or about July 31, 1970, the Board of Registered Nursing issued Registered Nurse License No. 209795 to Respondent Soledad Rodriguez Lopez. The Registered Nurse License

was in full force and effect at all times relevant to the charges brought in Accusation No. 2011-549, and expired on April 30, 2010, and has not been renewed.

4. On or about July 18, 1975, the Board of Registered Nursing issued Public Health Nurse Certificate No. 21280 to Respondent Soledad Rodriguez Lopez. The Public Health Nurse Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 2011-549 and expired on April 30, 2010, and has not been renewed.

JURISDICTION

5. Accusation No. 2011-549 was filed before the Board of Registered Nursing ("Board"), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 16, 2010. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 2011-549 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, and understands the charges and allegations in Accusation No. 2011-549. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

7. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 2011-549, if proven at a hearing, constitute cause for imposing discipline upon her Registered Nurse License and Public Health Nurse Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that at a hearing, the Board could establish a factual basis for the charges in the pending Accusation, and that Respondent hereby gives up her right to contest those charges.

11. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Registered Nurse License without further process.

12. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Public Health Nurse Certificate without further process.

CONTINGENCY

13. This stipulation shall be subject to approval by the Board of Registered Nursing. Respondent understands and agrees that counsel for Complainant and the staff of the Board of Registered Nursing may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

15. This Stipulated Surrender of License and Order is intended by the parties to be an integrated writing representing the complete, final, and exclusive embodiment of their agreement.

It supersedes any and all prior or contemporaneous agreements, understandings, discussions, negotiations, and commitments (written or oral). This Stipulated Surrender of License and Order may not be altered, amended, modified, supplemented, or otherwise changed except by a writing executed by an authorized representative of each of the parties.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Registered Nurse License No. 209795, and Public Health Nurse Certificate No. 21280 issued to Respondent Soledad Rodriguez Lopez, are surrendered and accepted by the Board of Registered Nursing.

1. The surrender of Respondent's Registered Nurse License and Public Health Nurse Certificate and the acceptance of the surrendered license and certificate by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Registered Nurse and Public Health Nurse in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board her pocket license(s) and certificate, and, if issued her wall certificates on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 2011-549 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Upon reinstatement of the license and public health certificate, Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of Nine Thousand Four Hundred and Fifity Five

Dollars and Fifty Cents ($9,455.50). Respondent shall be permitted to pay these costs in a payment plan approved by the Board.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 2011-549 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

7. Respondent shall not apply for licensure or petition for reinstatement for two (2) years from the effective date of the Board of Registered Nursing's Decision and Order.

ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Registered Nurse License, and Public Health Nurse Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Registered Nursing.

DATED: 3/11/2011 Soledad Rodriguez Lopez

SOLEDAD RODRIGUEZ LOPEZ
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Registered Nursing of the Department of Consumer Affairs.

DATED: MARCH 14, 2011

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
FRANK H. PACOE
Supervising Deputy Attorney General

JUDITH LOACH
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Accusation No. 2011-549

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SOLEDAD RODRIGUEZ LOPEZ** **3100 Kirkwood Road** **Corning, CA 96021** **Registered Nurse License No. 209795** **Public Health Nurse Certificate No. 21280** Respondent.	Case No. 2011-5749 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 31, 1970, the Board of Registered Nursing issued Registered Nurse License Number 209795 to Soledad Rodriguez Lopez ("Respondent"). The Registered Nurse License and expired on April 30, 2010, and has not been renewed.

3. On or about July 18, 1975, the Board of Registered Nursing issued Public Health Nurse Certificate Number 21280 to Respondent. The Public Health Nurse Certificate was in full

force and effect at all times relevant to the charges brought herein and expired on April 30, 2010, and has not been renewed.

JURISDICTIONAL STATUTES

4. This Accusation is brought before the Board of Registered Nursing ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 2750 of the Code provides in relevant part that:

"Every certificate holder or licensee, including licensees . . . holding license placed in an inactive status, may be disciplined as provided in this Article."

6. Section 2764 of the Code provides in relevant part that:

"The lapsing or suspension of a license by operation of law or by order or decision of the [B]oard or a court of law . . . shall not deprive the [B]oard of jurisdiction to proceed with any investigation or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license."

DISCIPLINARY STATUTES AND REGULATIONS

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

. . .

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single

situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

10. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

. . .

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

. . .

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

11. Section 2725.1 of the Code states that "[n]otwithstanding any other provision of law, a registered nurse may dispense drugs or devices upon an order by a licensed physician and surgeon . . . ".

12. Section 2726 of the Code states that "[e]xcept as otherwise provided herein, this chapter [the Nursing Practice Act] confers no authority to practice medicine or surgery."

COST RECOVERY

13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

MEDICATIONS

14. Epogen Alfa, is known by the brand names "Epogen "or "Procrit." It is a medication used to treat anemia related to chronic renal (kidney) failure by causing the bone marrow to produce more red blood cells, thus decreasing the need for blood transfusions. Procrit is administered subcutaneously and injected one to three times a week. This medication increases the risk of blood clots and requires that a patient's hemoglobin levels be monitored to ensure proper dosage.

15. Darbepoetin Alfa known by the brand name "Aranesp," is also used to treat anemia related to chronic renal failure. It is administered subcutaneously once a week every one to three weeks, versus one to three times a week as for Procrit. Based on laboratory results, the amount of Aranesp prescribed can be increased or decreased by 25 % of the previous dose, not more than once a month. As with Procrit, Aranesp increases the risk of blood clots with serious side effects including heart attack, stroke, heart failure and/or death.

STATEMENT OF FACTS

14. At all relevant times, Respondent was employed as a registered nurse in the Renal Clinic at the Alameda County Medical Center ("ACMC").

15. Prior to March 2006, Procrit was used in the Renal Clinic. Adjustments in the dosage and/or frequency of Procrit as administered by registered nurses were based on written protocols.

16. After March 2006, the Renal Clinic switched to Aranesp. Respondent was directed to obtain orders for all patients who had been receiving Procrit, and to have their physicians initiate the Aranesp Anemia Management Orders form which set forth the parameters for administering

this medication. There was no written protocol for registered nurses to adjust the dose and/or frequency of administering Aranesp to clinic patients, as there had been with Procrit.

17. In May 2006, Respondent advised her supervisor that the Renal Clinic physicians were using the Aranesp Anemia Management Orders form and that adjustments in the dose and/or frequency of administering Aranesp were done pursuant to physician orders. However, as set forth below, said representations were not true.

18. **Patient 1:**

a. On May 18, 2006, Patient 1's physician wrote an order for Aranesp 25 micrograms ("mcg") to be given every week, which was administered on this date by Respondent.

b. Six day later on May 24, 2006, Respondent again administered 25 mcg of Aranesp to Patient 1.

c. On June 22, 2006, Patient 1's physician ordered that the Aranesp be increased to 40 mcg each week, which was administered on this date by Respondent. Six days later on June 28, 2006, Respondent again administered 40 mcg of Aranesp to Patient 1.

d. On August 22, 2006, without a physician's order Respondent administered 100 mcg of Aranesp to Patient 1.

e. The Aranesp Anemia Management Orders for Patient 1 was not signed by a physician until August 24, 2006, and failed to set forth any orders for the administration of Aranesp.

19. **Patient 2:**

a. On April 7, 2006, Respondent administered 25 mcg of Aranesp to Patient 2 without a physician's order.

b. It was not until April 10, 2006, that Patient 2's physician wrote orders for Aranesp 25 mcg every week. On this date, Respondent administered 25 mcg of Aranesp to Patient 2, although Aranesp had been administered three days before.

c. On April 24, 2006, without a physician's order Respondent withheld administering Patient 2's weekly dose of Aranesp.

d. On April 27, 2006, Respondent administered 25 mcg of Aranesp to Patient 2. Six days later, Respondent again administered 25 mcg of Aranesp to Patient 2.

e. On May 23, 2006, without a physician's order Respondent withheld administering Patient 2's weekly dose of Aranesp.

f. On June 19, 2006, without a physician's order Respondent withheld administering Patient 2's weekly dose of Aranesp.

g. The Aranesp Anemia Management Orders for Patient 2 were not signed by a physician until August 24, 2006, and failed to set forth any orders for the administration of Aranesp.

20. **Patient 3:**

a. On March 14, 2006, Patient 3's physician wrote an order for Aranesp 40 mcg every week.

b. On March 23, 2006, Respondent administered 40 mcg of Aranesp to Patient 3. Four days later on March 27, 2006, Respondent again administered 40 mcg of Aranesp to Patient 3.

c. On April 17, 2006, without a physician's order Respondent withheld administering 40 mcg to Patient 3.

d. On June 1, 2006, Respondent administered 40 mcg of Aranesp to Patient 3. Four days later on June 5, 2006, Respondent again administered 40 mcg of Aranesp to Patient 3.

e. On June 19, 2006, without a physician's order Respondent administered 60 mcg of Aranesp to Patient 3.

f. On June 26, 2006, without a physician's order Respondent administered 60 mcg of Aranesp to Patient 3.

g. On July 10, 2006, without a physician's order Respondent administered 60 mcg of Aranesp to Patient 3.

h. On July 17, 2006, without a physician's order Respondent withheld administering Aranesp to Patient 3.

i. The Aranesp Anemia Management Orders for Patient 3 were not signed by a physician until August 24, 2006, and failed to set forth any orders for the administration of Aranesp.

21. **Patient 4:**

a. On August 3, 2006, Patient 4's physician wrote an order for Aranesp 100 mcg every week. Respondent on this date administered 85 mcg of Aranesp to Patient 4.

b. The Aranesp Anemia Management Orders for Patient 4 were not signed by a physician until August 24, 2006, and failed to set forth any orders for the administration of Aranesp.

22. **Patient 5:**

a. On May 18, 2006, Patient 5's physician wrote an order for Aranesp 40 mcg every two weeks. Respondent on this date administered 40 mcg of Aranesp to Patient 5.

b. On May 22, 2006, four days later Respondent again administered Aranesp 40 mcg to Patient 5.

c. On May 30, 2006, eight days later, Respondent again administered Aranesp 40 mcg to Patient 5.

d. Six days later on June 5, 2006, Respondent again administered Aranesp 40 mcg to Patient 5.

e. Seven days later on June 12, 2006, Respondent again administered Aranesp 40 mcg to Patient 5.

f. On July 20, 2005, Patient 5's physician wrote an order for Aranesp 60 mcg every week. Respondent administered the medication as ordered. Five days later, on July 25, 2006, Respondent again administered Aranesp 60 mcg to Patient 5.

g. Six days later, on July 31, 2006, Respondent again administered Aranesp 60 mcg to Patient 5.

h. The Aranesp Anemia Management Orders for Patient 5 were not signed by a physician until August 24, 2006, and failed to set forth any orders for the administration of Aranesp.

23. **Patient 6:**

a. On March 23, 2006, Respondent administered 25 mcg of Aranesp to Patient 6, without an order from a physician.

b. On March 24, 2006, Respondent wrote that Patient 6's physician had ordered that the Aranesp dose be decreased to every other week. Respondent failed to include the dose and/or frequency of Aranesp to be given as ordered by Patient 6's physician.

c. On June 27, 2006, Respondent administered 40 mcg to Patient 6, without an order from a physician.

d. The Aranesp Anemia Management Orders for Patient 6 were not signed by a physician.

24. **Patient 7:**

a. On March 16, 2006, Patient 7's physician wrote an order for Aranesp 25 mcg every week.

b. On June 22, 2006, Respondent administered 40 mcg of Aranesp to Patient 7, without a physician order.

25. **Patient 8:**

a. On June 22, 2006, Respondent administered Aranesp 60 mcg to Patient 8, without a physician order.

b. On June 27, 2006, Respondent administered Aranesp 60 mcg to Patient 8, without a physician order.

c. On August 17, 2006, Patient 8's physician wrote an order for Aranesp 200 mcg every week.

d. Four days later on August 21, 2006, without a physician's order Respondent administered 100 mcg of Aranesp to Patient 8.

e. Three days later on August 24, 2006, without a physician's order Respondent again administered 100 mcg of Aranesp to Patient 8.

f. Four days later on August 28, 2006, without a physician's order Respondent again administered Aranesp 100 mcg to Patient 8.

g. The Aranesp Anemia Management Orders for Patient 8 were not signed by a physician until August 24, 2006

26. **Patient 9:**

a. On May 25, 2006, Patient 9's physician wrote an order for 40 mcg of Aranesp every week.

b. On June 12, 2006, without a physician order Respondent administered 60 mcg of Aranesp to Patient 9.

c. On June 23, 2006, without a physician's order Respondent withheld administering Aranesp to Patient 9.

d. The Aranesp Anemia Management Orders for Patient 9 were not signed by a physician.

27. **Patient 10:**

a. On June 1, 2006, Patient 10's physician wrote an order for 40 mcg of Aranesp every month.

b. On July 3, 2006, Respondent administered 25 mcg of Aranesp to Patient 10.

c. On July 20, 2006, Patient 10's physician wrote an order to restart the Aranesp. The dosage of Aranesp was not noted in the order nor did the physician's order include the frequency that Aranesp was to be given. Respondent, without a complete physician's order, administered 25 mcg to Patient 10 on July 20, 2006.

d. On July 27, 2006, Respondent without a complete physician order administered 25 mcg to Patient 10.

e. On August 3, 2006, Respondent without a complete physician order administered 25 mcg to Patient 10.

f. On August 14, 2006, Respondent without a complete physician order administered 25 mcg to Patient 10.

28. **Patient 11:**

a. On March 16, 2006, Patient 11's physician wrote an order for 25 mcg of Aranesp every week.

b. On March 24, 2006, without a physician's order Respondent withheld administering Aranesp to Patient 11.

c. On April 4, 2006, without a physician's order Respondent withheld administering Aranesp to Patient 11 for three weeks.

d. On April 28, 2006, Respondent administered 25 mcg of Aranesp and instructed Patient 11 to return to the Renal Clinic in two weeks, despite the March 16 order for Aranesp to be administered every week.

e. On June 12, 2006, without a physician order Respondent administered 40 mcg of Aranesp to Patient 11.

f. On June 19, 2006, without a physician order Respondent administered 40 mcg of Aranesp to Patient 11.

g. On June 26, 2006, without a physician order Respondent administered 40 mcg of Aranesp to Patient 11.

h. On July 3, 2006, without a physician order Respondent administered 40 mcg of Aranesp to Patient 11.

i. On July 10, 2006, without a physician order Respondent withheld administering Aranesp to Patient 11 for two weeks.

j. On July 24, 2006, without a physician order, Respondent administered 40 mcg of Aranesp to Patient 11. She instructed Patient 11 to return to the Renal Clinic in two weeks, despite the March 16, 2006, order for Aranesp to be administered every week.

k. On August 7, 2006, without a physician order Respondent administered 40 mcg of Aranesp to Patient 11. She instructed Patient 11 to return to the Renal Clinic in two weeks, despite the March 16, 2006, order for Aranesp to be administered every week.

l. On August 21, 2006, without a physician order Respondent withheld administering Aranesp to Patient 11. In progress notes, without a physician order, Respondent noted that the Aranesp to be administered to Patient 11 was to be held for three weeks.

m. The Aranesp Anemia Management Orders for Patient 11 were not signed by a physician until August 24, 2006.

29. **Patient 12:**

a. On May 11, 2006, Patient 12's physician wrote an order for Aranesp 60 mcg to be administered weekly.

b. On July 14, 2006, without a physician's order Respondent administered 100 mcg of Aranesp to Patient 12.

c. On July 28, 2006, without a physician's order Respondent administered 100 mcg of Aranesp to Patient 12.

d. On August 11, 2006, without a physician's order Respondent administered 100 mcg of Aranesp to Patient 12.

e. On August 18, 2006, without a physician's order Respondent administered 100 mcg of Aranesp to Patient 12.

f. On August 25, 2006, without a physician's order Respondent withheld administering Aranesp to Patient 12.

g. The Aranesp Anemia Management Orders for Patient 12 were not signed by a physician until August 24, 2006.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence – Administering Medication Without a Physician Order)

30. Respondent is subject to disciplinary action for gross negligence and/or incompetence under Code section 2761, subdivision (a)(1), in that without physician orders she gave and/or adjusted the amount of Aranesp administered to patients in the Renal Clinic at ACMC. The circumstances giving rise to this cause for discipline are as set forth above in: Paragraph 18, subdivision (d), Paragraph 19, subdivision (a), Paragraph 20, subdivisions (e), (f) and (g), Paragraph 21, subdivision (a), Paragraph 23, subdivisions (a) and (c), Paragraph 24, subdivision (b), Paragraph 25, subdivision (a), (b) and (d) through (f), Paragraph 26, subdivision (b), Paragraph 27, subdivisions (b) through (f), Paragraph 28, subdivisions (d) through (h) and (j) through (l), and Paragraph 29, subdivisions (b) through (f).

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SECOND CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence – Administration of Medication More Frequently than Ordered)

31. Respondent is subject to disciplinary action for gross negligence and/or incompetence under Code section 2761, subdivision (a)(1), in that she administered Aranesp to Renal Clinic patients more frequently than as prescribed by physician orders. The circumstances giving rise to this cause for discipline are set forth above in: Paragraph 18, subdivisions (b) and (c), Paragraph 19, subdivisions (b) and (d), Paragraph 20, subdivisions (b) and (d), Paragraph 22, subdivisions (b) through (g), and Paragraph 25, subdivisions (e) through (f).

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence – Withholding Administration of Medication as Ordered)

32. Respondent is subject to disciplinary action for gross negligence and/or incompetence under Code section 2761, subdivision (a)(1), in that she withheld administration of Aranesp to Renal Clinic patients without physician orders. The circumstances giving rise to this cause for discipline are set forth above in: Paragraph 19, subdivisions (c), (e) and (f), Paragraph 20, subdivisions (c) and (h), Paragraph 26, subdivision (b), and Paragraph 28, subdivisions (b), (c) and (i) and Paragraph 29, subdivision (f).

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Unintelligible Chart Entries Regarding Medication Orders)

33. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2761, subdivision (a), in that she made unintelligible entries of physician orders for Aranesp that failed to include the dosage and/or frequency for administration of this medication to Renal Clinic patients. The circumstances in support of this cause for discipline are set forth above in Paragraph 23, subdivision (b) and Paragraph 27, subdivision (e).

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Dishonesty Regarding Initiation of Aranesp Anemia Management Orders)

34. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2761, subdivision (a), in that she was dishonest when she informed her supervisor that

physicians had initiated and were using the Aranesp Anemia Management Order form for Renal Clinic patients. The circumstances giving rise to this cause for discipline are set forth above in: Paragraph 18, subdivision (e), Paragraph 19, subdivision (g), Paragraph 20, subdivision (i), Paragraph 21, subdivision (b), Paragraph 22, subdivision (h), Paragraph 23, subdivision (d), Paragraph 25, subdivision (g), Paragraph 26, subdivision (d), Paragraph 28, subdivision (m), and Paragraph 29, subdivision (g).

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 209795, issued to Soledad Rodriguez Lopez.

2. Revoking or suspending Public Health Nurse Certificate Number 21280, issued to Soledad Rodriguez Lopez.

3. Ordering Soledad Rodriguez Lopez to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3.

4. Taking such other and further action as deemed necessary and proper.

DATED: 12/16/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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